STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE	3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	A. BUILDING 00			COMPLETED	
				B. WING			07/03/2014	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R						
CDOWN	POINTE OF CARM	ırı	11610 TECHNOLOGY DR CARMEL, IN 46032					
CROWN	POINTE OF CARIVI			CARIVI	EL, IN 40032			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
R000000								
	This visit was for the Investigation of Complaint IN00148969.		R00	00000	Submission of this plan of			
					correction does not constitute			
	•				admission or agreement by th	е		
	Complaint IN00148969 Substantiated.				provider of the truth of facts	on		
	_				alleged or correction set forth the statement of deficiencies.	UH		
	State deficiencies related to the allegations are cited at R0036, R0148, R0241, 0247 and R0301.				This plan of correction is			
					prepared and submitted as a			
					requirement under state and			
					federal law. Please accept this	S		
	Survey Dates:				plan of correction as our credi			
	July 2 & 3, 2014 Facility number: 012309				allegation of compliance.			
	_							
	Provider numbe							
	AIM number: N	NA						
	Survey Team:							
	Mary Jane G. Fi	scher RN						
		Solier Terv						
	C 1 1.							
	Census bed type							
	Residential: 24							
	Total: 24							
	Census payor ty	pe:						
	Other: 24	•						
	Total: 24							
	10111. 27							
	G 1 4							
	Sample: 4							
	Supplemental sa	imple: 2						
	These State Res	idential findings are cited						
	in accordance with 410 IAC 16.2-5.							
		· · · · · ·						
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURI	7	TITLE		(X6) DATE	

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 20 State Form Event ID: 6NUC11 Facility ID: 012309 If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		07/03/2014
	PROVIDER OR SUPPLIER		11610	ADDRESS, CITY, STATE, ZIP CODE TECHNOLOGY DR EL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		was completed by N on July 7, 2014.			
R000036	resident's physic legal representation noticed: (1) a significant dephysical, mental, of (2) a need to alter that is, a need to ofform of treatment consequences or of treatment. Based on record facility failed to family member aphysician was not intervention to a treatment, in that physician orders medication the minform the physic receive the presentation of the presentation of the presentation of the physician orders applied to the presentation of the physician orders applied to the presentation of the physical receive the presentation of the physical physical physical orders. Findings includes the record for Reviewed on 07-to Diagnoses includes the presentation of the physical physi	st immediately consult the ian and the resident's we when the facility has ecline in the resident's or psychosocial status; or treatment significantly, discontinue an existing due to adverse to commence a new form review and interview the ensure a concerned and the resident's otified for possible lter medication t when a resident had for a specific pain pursing staff failed to ician the resident did not cribed treatment for 1 of 4 ts. (Resident "B")	R000036	1.Resident B was not harmed. The order for Butrans patch has been clarified upon physician notification and the responsible party was notified. 2.All residents utilizing pain medications have the potential be affected. All medication can were checked with the medical administration records to ensurall ordered medications were present. All nurses and QMA's were re-educated on the facility policy on Notification of Changes and Compliance the DON or design will review the 24 report sheed daily on regularly scheduled dof work ongoing to monitor for any changes in condition and proper documentation of physician and responsible particular services.	ad le al to rts ation ure s ty's ges. nee tdays

State Form Event ID: 6NUC11 Facility ID: 012309 If continuation sheet Page 2 of 20

ì ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
			B. WIN			07/03/2	014
					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				TECHNOLOGY DR		
	POINTE OF CARMI	EL		CARME	EL, IN 46032		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		\	DATE
	agitation, low back pain radiating down				notification, (seeattachment A 4.As a measure of quality).	
		pertension. These			assurance the DON will comp	lete	
	_	ned current at the time of			the above described monitoring		
	the record review	V.			ongoing. Should a deficient		
					practice be observed, immedia		
	The resident had	original physician			corrective action will be taken.		
	orders, dated 01-	27-13 for Butrans (a			The plan of correction will be revised accordingly, if warrant	_{ed}	
	transdermal medication patch for pain) 10 mcg/hr (micrograms per hour) - apply 1 patch topically and change every week				The Administrator will monitor		
					and sign off on the monitoring		
					tools on a monthly basis ongo		
	on Sunday.				5.The above corrective action	I .	
	on Sunday.				will be completed on or before July 16, 2014.	;	
	A review of the Medication				July 10, 2014.		
		Record for September					
		ne resident had the					
	•	h applied on 09-01-13.					
	Further review o						
		Record indicated the					
		"not available" for the					
	resident on 09-08	8-13 or 09-15-14.					
	During an interv	iew on 07-02-14 at 12:00					
	_	d family member					
		ook [resident] to the pain					
		e continued to have pain.					
		around the middle of					
		B] and at first we thought					
	the pain medicat						
		doctor increased the					
	patch to a 5 mcg patch and a 10 mcg						
	patch to be put on at the same time, once						
	a week. Originally the staff told me the						
	patch was not in	the cabinet, but we knew					
	it had been deliv	ered. I spoke with the					

State Form Event ID: 6NUC11 Facility ID: 012309 If continuation sheet Page 3 of 20

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBEK:	A. BUILDING	00		3/2014
			B. WING			J/2U 14
NAME OF F	ROVIDER OR SUPPLIEF	1		ADDRESS, CITY, STATE, ZIP CO	DDE	
CROWNI	POINTE OF CARM	FI		ECHNOLOGY DR L, IN 46032		
				L, 114 TOOOL		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION
TAG	•	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
		istrator and after she				
	_	s when we found out that				
		h was there and had not				
	been applied as ordered."					
	oran apparent an					
	A review of the	resident's record lacked				
		he physician or the				
family members were notified of the						
	situation with the "unavailability" of the					
transdermal pain medication.						
	•					
	A review of the facility policy on					
	07-03-14 at 11:0	00 a.m., titled				
	"NOTIFICATIO	ON OF CHANGES," and				
	dated 12-03 (200	03) indicated the				
	following:					
	"POLICY: This	facility shall				
	immediately info	orm the resident, consult				
	with the resident	s's physician, and, if				
	known notify the	e resident's legal				
	representative or	an interested family				
		nere is: (3) a need to alter				
		adverse consequences or				
		new form of treatment;				
	"					
		1.) All notification				
	•	er telephone, via fax, or in				
		ded in the resident				
	medical record."	1				
		g relates to Complaint				
	IN00148969.					

State Form Event ID: 6NUC11 Facility ID: 012309 If continuation sheet Page 4 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
			B. WING		07/03/2014		
			STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			TECHNOLOGY DR			
CROWN	POINTE OF CARME	≣L	CARMEL, IN 46032				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
R000148	(e) The facility sha grounds, and equi condition, in good that may adversely welfare of the reside follows: (1) Each facility sha implement a writter maintenance to enupkeep of the facility. The electrical sappliances, cords, sources, fire alarm shall be maintaine functioning and concept electrical codes. (3) All plumbing shacomply with state (4) At least yearly, systems shall be in Based on observe facility failed to good repair and thazards, in that we family members in regard to plum facility failed to remedy the situal resident to be explazard for 2 of 5 of 4 sampled and	fety Standards - Deficiency all maintain buildings, pment in a clean repair, and free of hazards of affect the health and dents or the public as shall establish and in program for asure the continued ity. By system, including switches, alternate power in and detection systems, die to guarantee safe impliance with state in all function properly and plumbing codes. The health and interview, the ensure the building inferee from potential when the residents and alerted the facility staff in abing problems, the fact immediately to tion, and allowed a posed to a potential fall rooms observed and 2 in 1 of 2 supplemental	R000148	1.Residents A, B, and E wer not harmed. The plumbing problems have been repaired. 2.All residents residing in the facility have the potential to be affected. The maintenance ma completed rounds throughout entire facility to monitor for any further plumbing problems with none noted. 3.As a measure of ongoing compliance the maintenance ror designee will complete round throughout the facility monitori	the / / / / / / / / / / / / / / / / / / /		
	sampled resident	. (Residents "A", "B"					

State Form Event ID: 6NUC11 Facility ID: 012309 If continuation sheet Page 5 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED		
						07/03/	2014	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	ROVIDER OR SUPPLIER	8						
CDOMMI			11610 TECHNOLOGY DR CARMEL, IN 46032					
CROWN	POINTE OF CARM	EL		CARIVIE	EL, IN 46032			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	and "E").				for leaks and/or other plumbing	g		
	Findings include:			issues weekly for four weeks,				
					then every two weeks for four			
					weeks, then monthly ongoing,			
					(see attachment B). Additional			
	_	iew on 07-02-14 at 12:02			staff have been advised of the completion of maintenance			
	_	d family member			requisitions for known, observe	ed		
	indicated the floor to her parents room, was frequently observed with water on the floor. "There was flooding in the room and I was just appalled. The water seemed like it was coming from the room				or resident/family reported			
					concerns in an effort to			
					communicate the same to the			
					Administrator and maintenanc	е		
					department.			
		s told the person who			4.As a measure of quality			
		et the shower run too			assurance the maintenance m or designee will complete the	an		
					above described monitoring			
	_	wer was overflowing.			ongoing. Should a deficient			
		et was wet, as well as the			practice be observed, immediate			
	bathroom floor.	The water, from the wall	corrective action will be taken.					
	and outward mea	asured 2 1/2 to 3 feet.		The plan of correction will be				
	My parents had	to keep putting towels			revised accordingly, if warrant			
		the water. The staff told			The Administratorwill monitor and			
		ave to bring in someone			sign off on the monitoring tools	s on		
	_	_			a monthly basis ongoing.5.The above corrective action	n		
		to dry everything out. It			will be completed on or before			
		mes the week we moved			July 16, 2014.			
		of the facility. They had			· · · · · ·			
	me moved some							
	belongings in the	e hallway. It didn't						
	happen only onc	e either. It occurred						
	periodically sinc	e the fall of last year						
		them to call the property						
		ey told me he couldn't do						
	_	ually I spoke with the						
		-						
	Executive Direct	tor.						
	-	iew on 07-02-14 at 12:10						
	p.m., the housek	eeper verified the						

State Form Event ID: 6NUC11 Facility ID: 012309 If continuation sheet Page 6 of 20

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 07/03/2014		
	PROVIDER OR SUPPLIER		116 ⁻	IO TEC	ress, city, state, zip code CHNOLOGY DR IN 46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	· .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	adjacent to the rofamily member's housekeeper indiroom with plumber the water, and put it's just not clean Resident "E," the the shower head stream of water a placed adjacent to bathroom flooring shower and the coobservation, the shower head has 3 weeks. The way onto the floor. To looked at it but he do." During an interview, the mainter there was a problem the drainage the member spoke of concerns of Residual leaking. "If from corporate to it. Yes it's been sweeks."	g was wet between the ommode. During this resident indicated "the been like this for about ater keeps splashing out the maintenance man e didn't know what to liew on 07-02-14 at 12:30 mance man indicated tem with the shower and concerned family					
	Director verified	•					

State Form Event ID: 6NUC11 Facility ID: 012309 If continuation sheet Page 7 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED		
			B. WING		07/03/2014
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			FECHNOLOGY DR	
CROWNF	POINTE OF CARME	≣L		EL, IN 46032	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	plumbing proble	ms, as noted by the			
	concerned family member and indicated the repair involved tearing out part of the				
	•	remedy the plumbing			
		ition the Executive			
		ledged the problems			
	•	ng in Resident "E"			
		cated he was unsure if			
		be completely turned off			
	to repair the leak. This State finding relates to Complaint				
		g relates to Complaint			
	IN00148969.				
R000241	410 IAC 16.2-5-4(
	Health Services - (
		tion of medications and			
	•				
	•				
	licensed nursing p	ersonnel or qualified			
	medication aides.				
	Based on record	review and interview the	R000241		
	facility failed to	ensure the physician			е
	orders were follo	owed, and residents			cv.
	without medicati	on errors, in that when		2.All residents requiring	
	residents had spe	ecific physician orders		medications to be administere	
	•	1 2		by staff have the potential to b	
		,			
	_				y s
		-			
		-		designee has completed	
	(Residents A,	D und D J.		medication administration	
	the provision of residential nursing care shall be as ordered by the resident 's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview the facility failed to ensure the physician orders were followed, and residents without medication errors, in that when residents had specific physician orders for medication administration, the nursing staff failed to ensure the residents received the medications as ordered by the physician for 3 of 4 sampled residents (Residents "A", "B" and "D").		R000241	medications to be administered by staff have the potential to be affected. All nurses and QMA's were re-educated on the facilit policy on Medication Administration. The DON or designee has completed	cy. d e s

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	COMPLETED	
			B. WIN			07/03/2014
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				TECHNOLOGY DR	
CROWNI	POINTE OF CARMI	EL			EL, IN 46032	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Findings include 1. The record for reviewed on 07-0 Diagnoses included, insulin dependent of the record review. The record review of the record indicated the resident of the facility. A review of the diagnose of the record indicated the resident of the record indicated for the record indicated the resident of the record indicated for the record indicated the resident of the record indicated the resident of the record indicated for the record indicated the resident of the record indicated for the record	r Resident "A" was 02-14 at 10:10 a.m. ded, but were not limited dent diabetes mellitus, arthritis. These ned current at the time of v. ated the Resident had dated 12-17-12 for /ml (milliliters) 64 units eous) every day. ated the resident was ocal area hospital on urned to the facility on s instructed the nurse to ent received Lantus daily sub-Q upon return			observations on all nurses and QMA's with satisfactory performance noted. 3.As a measure for ongoing compliance the DON or design will complete medication administration observations, (sattachment C) weekly for four weeks, then every two weeks four weeks, then monthly ongoing. Additionally all new medication orders will be checked by two staff members to monif for correct transcription. 4.As a measure of quality assurance the DON will comp the above described monitoring ongoing. Should a deficient practice be observed, immedia corrective action will be taken. The plan of correction will be revised accordingly, if warrant The Administrator will monitor and sign off on the monitoring tools on a monthly basis ongo 5. The above corrective action will be completed on or beforeJuly 16, 2014.	nee see for sked tor lete ng ate ed. ing.
		Accuchecks for March ne resident's 8:00 a.m.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
			B. WING		07/03/2014		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	Accuchecks wer 120 on March 19, 98 on March 10, 56 on March 11, 72 on March 12, 40 on March 13, 56 on March 14, A review of the Notes, dated 07-for 03-13-13 ind "I [myself] notif Nurses] that resiconfused. DON resident and notified family, was visiting. ReDON decided to also per family resent to hospital 9. 2. The record for reviewed on 07-Diagnoses included, acute encephalication, low balloth legs, and hydiagnoses remains the record reviewed. The resident had	re as follows: 2014, 2014, 2014, 2014, 2014, 2014. Interdisciplinary Progress 03-14, as a "late entry" ficated the following: fied DON [Director of dent had fallen and was went around to check on ficed blood sugar was fied [physician name], also [family member] resident was confused so send resident out 911 request. Resident was 02-14 at 1:10 p.m. ded, but were not limited alopathy with severe fieck pain radiating down repertension. These fined current at the time of fiv.					
	orders, dated 01	-27-13 for Butrans (a					

State Form Event ID: 6NUC11 Facility ID: 012309 If continuation sheet Page 10 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPI				
			A. BUILDING B. WING		07/03	/2014		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	10 mcg/hr (micr	lication patch for pain) ograms per hour) - apply and change every week						
	2013 indicated t transdermal pate Further review of Administration I medication was	Medication Record for September the resident had the th applied on 09-01-13. of the Medication Record indicated the "not available" for the 8-13 or 09-15-14.						
	During an interview on 07-02-14 at 12:00 p.m., a concerned family member indicated "We took [resident] to the pain clinic because he continued to have pain. I believe it was around the middle of September [2013] and at first we thought the pain medication needed to be increased. The doctor increased the patch to a 5 mcg patch and a 10 mcg patch to be put on at the same time, once a week. Originally the staff told me the patch was not in the cabinet, but we knew it had been delivered. I spoke with the Regional Administrator and after she investigated it, is when we found out that the original patch was there and had not been applied as ordered."							
	A review of the indicated the res	resident's record ident had a change in the						

State Form Event ID: 6NUC11 Facility ID: 012309 If continuation sheet Page 11 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
			B. WIN			07/03/	2014
			Б. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R		1	ECHNOLOGY DR		
CROWN	POINTE OF CARM	FI	CARMEL, IN 46032				
				<u> </u>	, 114 40002		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	dosage of the pain transdermal patch on						
	03-27-14. The physician order instructed						
	the nurse to appl	ly a 5 mcg/hr patch. This					
	physician order	was dated 03-27-14 and					
	instructed the nu	irse "Replaces Butrans 15					
	mcg/hr patch."	•					
	meg m patem						
	A review of the Controlled Record						
	indicated "Butran 15 mcg/hr - apply 1						
	0 11.7						
	patch weekly for pain, rotating sites. The						
	record indicated on 03-30-14 at 8:00						
	a.m., the 15 mcg/hr patch had been						
	applied to the re	sident.					
	A review of the	Medication Record for					
	March 2014 indi	icated the resident also					
	received the 5 m	ncg/hr patch on 03-30-14.					
	Further interviev	w on 07-02-14 at 12:00					
		ed family member					
	* '	the resident arrived at					
	_	y," [resident] had on two					
		ne was for 5 mcg/hr and					
		r 15 mcg/hr and were					
	"dated 03-30-14	."					
	3. The record for	or Resident "D" was					
	reviewed on 07-	02-14 at 2:30 p.m.					
		ded, but were not limited,					
	to diabetes melli						
		epression and renal					
		diagnoses remained					
		•					
	current at the tin	ne of the record review.					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/03/2014			
	PROVIDER OR SUPPLIER IPOINTE OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION			
	Review of the resident's record indicated the resident had specific physician orders for medications to be administered at 8:00 p.m.						
	During an interview on 07-03-14 at 10:00 a.m., the Director of Nurses verified the resident did not receive the scheduled medications as ordered. The Director of Nurses indicated the medications included Atorvastatin 10 mg (a medication for cholesterol), Levetiracetam 500 mg (a medications for seizures), and Lyrica 50 mg (a medication for neuropathy), until 1 1/2 hours after the scheduled time. "All of the oral 8:00 p.m. medications were given at 9:30 p.m."						
	4. A review of the facility policy on 07-03-14 at 11:00 a.m., titled "Medication Administration Policy and Procedure," and dated 09-05 (2005), indicated the following:						
	"PURPOSE: To administer medications according to the guidelines set forth by the State and Federal regulations."						
	"PROCEDURE: 1. Medications will be administered within 60 minutes before and/or after the time ordered."						
	This State finding relates to Complaint						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING	00	(X3) DATE SURVEY COMPLETED 07/03/2014		
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL			STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION		
R000247	shall be noted in the physician shall be medication administration and any actual or pote the resident. Based on record facility failed to were followed, in had specific physical medication, the resident medication was a need for possible for additional or residents. (Residents.) (Residents.) (Residents)	Deficiency edication administration the resident 's record. The notified of any error in stration when there are notial detrimental effects to review and interview the ensure physician orders in that when a resident sician orders for nursing staff failed to not's physician the not available and the exphysician intervention ders for 1 of 4 sampled dent "B"). : esident "B" was 102-14 at 1:10 p.m. Ided, but were not limited allopathy with severe ck pain radiating down expertension. These need current at the time of	R000247	1.Resident B was not harm. The order for Butrans patch been clarified upon physiciar notification and the responsil party was notified. 2.All residents utilizing pair medications have the potentibe affected. All medication cwere checked with the medicadministration records to ensall ordered medications were present in the cart. All nurses QMA's were re-educated on facility's policy on Notification Changes. 3.As a measure for ongoin compliance the DON or designating the policy of the daily onregularly scheduled congoing to monitor for any changes in condition and/or medication issues and proped documentation of physician a responsible party notification (see attachment A). 4.As a measure of quality assurance the DON will com the above described monitor ongoing. Should a deficient practice be observed, immedication incomposition of the state of the process of the party of the practice be observed, immedication incomposition of the practice of	had n ble n ial to arts cation sure e s and the n of g gnee et days er and l, plete ing		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII	LDING	00	COMPL	ETED
			A. BUII B. WIN			07/03/	2014
		l	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				FECHNOLOGY DR		
CROWN	POINTE OF CARMI	EL			EL, IN 46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
	transdermal med	ication patch for pain)			corrective action will be taken.		
	10 mcg/hr (micro	ograms per hour) - apply			The plan of correction will be revised accordingly, if warrant	ad	
	1 patch topically	and change every week			The Administrator will monitor		
	on Sunday.				and sign off on the monitoring		
					tools on a monthly basis ongo		
	A review of the	Medication			5.The above corrective action		
		Record for September			will be completed on or before		
		ne resident had the			July 16, 2014		
		h applied on 09-01-13.					
	_						
	Further review o						
		Record indicated the					
		"not available" for the					
	resident on 09-08	8-13 or 09-15-14.					
	During an interv	iew on 07-02-14 at 12:00					
	p.m., a concerne	d family member					
	indicated "We to	ook [resident] to the pain					
	clinic because he	e continued to have pain.					
	I believe it was a	around the middle of					
	September [2013	3] and at first we thought					
	the pain medicat	_					
		doctor increased the					
		patch and a 10 mcg					
		n at the same time, once					
	1 *	ly the staff told me the					
	_	=					
	_	the cabinet, but we knew					
	it had been delivered. I spoke with the Regional Administrator and after she investigated it, is when we found out that						
		h was there and had not					
	been applied as of	ordered."					
		resident's record lacked					
	documentation tl	ne physician was notified					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JETIPLE CO.	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
			B. WIN			07/03/2014	
			-		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ECHNOLOGY DR		
CROWN	POINTE OF CARME	EL			L, IN 46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG				TAG	DEFICIENCY)	DATE	
	of the situation w	vith the "unavailability"					
	of the transderma	al pain medication.					
	A review of the f 07-03-14 at 11:00 "NOTIFICATIO dated 12-03 (200 following:	0 a.m., titled N OF CHANGES," and					
	with the resident's known notify the representative or member when the treatment due to	orm the resident, consult 's physician, and, if					
	•	g relates to Complaint					
	IN00148969.						
R000301	(5) Labeling of pre include the followir (A) Resident's ful (B) Physician's na (C) Prescription nu (D) Name and stre (E) Directions for u (F) Date of issue a applicable).	ervices - Deficiency scription drugs shall ng: I name. ame. umber. ength of the drug. use. and expiration date (when					

State Form Event ID: 6NUC11 Facility ID: 012309 If continuation sheet Page 16 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
			B. WING 07/03/2014				2014	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIEF	8			TECHNOLOGY DR			
CROWNI	CROWNPOINTE OF CARMEL				EL, IN 46032			
					1			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
		ackaged in a unit dose, ions that comply with the						
		aceutical procedures are						
	permitted.	naccancal procedures are						
		servation, interview and	R00	00301	1.Resident C and F were no	t	07/16/2014	
		e facility failed to ensure			harmed. Resident C's orders			
		abeling of prescription			were clarified. A "direction			
		1 of 4 sample and 1 of 2			change"label was added to resident F's Ropinirole medica	ution		
		mpled residents reviewed			label immediately upon noting			
	* *	tion administration			discrepancy.			
	-				2.All residents requiring			
	observation. (Re	esidents "C" and "F").			medication have the potential to			
					be affected. All medication lab			
	Findings include	· ·			were compared to the medical administration records to ensu			
					the labels were accurate,	i e		
	1. The record for	or Resident "C" was			"direction change"labels applied	ed		
	reviewed on 07-	02-14 at 9:10 a.m.			as warranted.			
	Diagnoses inclu	ded, but were not limited			3.As a measure for ongoing			
	to, diabetes, cere	ebral vascular accident,			compliance the DON or design	nee		
	coronary artery	disease, congestive heart			will complete medication administration observations, (s			
		e renal failure. These			attachment C) weekly for four	see		
	diagnoses remai	ned current at the time of			weeks, then every two weeks	for		
	the record review				four weeks, then monthly			
		•••			ongoing.			
	The record indic	eated the resident had a			4.As a measure of quality	-4-		
		n February 2014. Upon			assurance the DON will complete the above described monitoring			
		, ,			ongoing. Should a deficient	9		
	discharge from t	•			practice be observed, immedia	ate		
	_	ructions," included			corrective action will be taken.			
		lin to be administered if			The plan of correction will be			
	needed for sliding scale insulin coverage				revised accordingly, if warrant			
	for specific bloo	d sugar ranges.			The Administrator or Regional			
					Director will monitor and sign on the monitoring tools on a	ווע		
	A review of the	physician re-writes for			monthly basis ongoing.			
		nuary 2014, February			5.The above corrective action	n		
		2014, instructed the			will be completed on or			
		the use of HumaLOG			beforeJuly 16, 2014			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC		r í	ATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
			B. WING			03/2014	
NAME OF 1	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP (CODE		
				TECHNOLOGY DR			
CROWN	POINTE OF CARM	EL	CARME	EL, IN 46032			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COI	RRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETION	
TAG			TAG	DEFICIENCY)		DATE	
	insulin.						
ı							
	However the Ap	oril 2014 and May 2014					
ı	physician re-wri	ites instructed the nursing					
İ	staff to use Nove	oLOG insulin.					
ı							
	During the daily	Exit conference on					
		0 p.m. the Director of					
	Nurses indicated	d the "resident had never					
		OG insulin, only					
	NovoLOG insulin."						
	Trovollo o mou						
	The resident's re	ecord lacked a physician					
		ation of the type of					
		ent should receive.					
	insum the resid	ent should receive.					
	During on inter-	views on 07 02 14 at 10:05					
	1	view on 07-03-14 at 10:05					
	1	or of Nurses verified she					
	1 ^	nurse practitioner who					
		anted the resident to					
		LOG insulin. The					
		ses further indicated a					
		er had not been written					
	_	of the nurse practitioner					
	until 07-03-14.						
		vation of a medication					
	administration o	on 07-02-14 at 8:15 a.m.,					
	The QMA (Qua	lified Medication Aide)					
	prepared the me	dications for Resident					
l	"F."						
l							
	The medications	s included Ropinirole (a					
	medication for F	Parkinson's disease). The					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
			B. WIN	G		07/03	/2014	
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET A	DDRESS, CITY, STATE, ZIP CODE			
					ECHNOLOGY DR			
CROWN	POINTE OF CARM	EL		CARME	L, IN 46032			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		le instructed the staff to						
	administer "2 - 1	l milligram tablets to the						
	resident two tim	es a day."						
	A review of the	Medication						
	Administration I	Record for July 2014 the						
	physician order	dated 06-01-14,						
		L 2 mg table <sic> 1</sic>						
	_	two times a day."						
	During the reconciliation of the resident drug regime indicated the specific							
	0 0	dated 06-01-14 indicated						
		2 mg table <sic> 1 tablet</sic>						
	_							
	by mouth two ti	mes a day.						
	Duning on intern	riovy on 07 02 14 at 0:00						
		view on 07-03-14 at 9:00						
		ate nurse consultant						
		ling needed to be						
	corrected.							
		facility policy on						
	07-03-14 at 11:0	-						
	"Medication Ad	ministration Policy and						
	Procedure," and	dated 09-05 (2005),						
	indicated the fol	lowing:						
	"Purpose: To A	dminister medications						
	according to the guidelines set forth by							
	_	deral regulations."						
		-						
	"Procedure: 2.)	Medications will be						
	· · · · · · · · · · · · · · · · · · ·	to verify order with label						
	during set up."	. ,						
	Laning set up.							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Δ RIII	LDING	00	COMPI	LETED	
			B. WIN			07/03	/2014
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL				STREET A	ADDRESS, CITY, STATE, ZIP CODE ECHNOLOGY DR EL, IN 46032	1	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	labeling of the m	f failed to ensure correct nedication. g relates to Complaint					

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